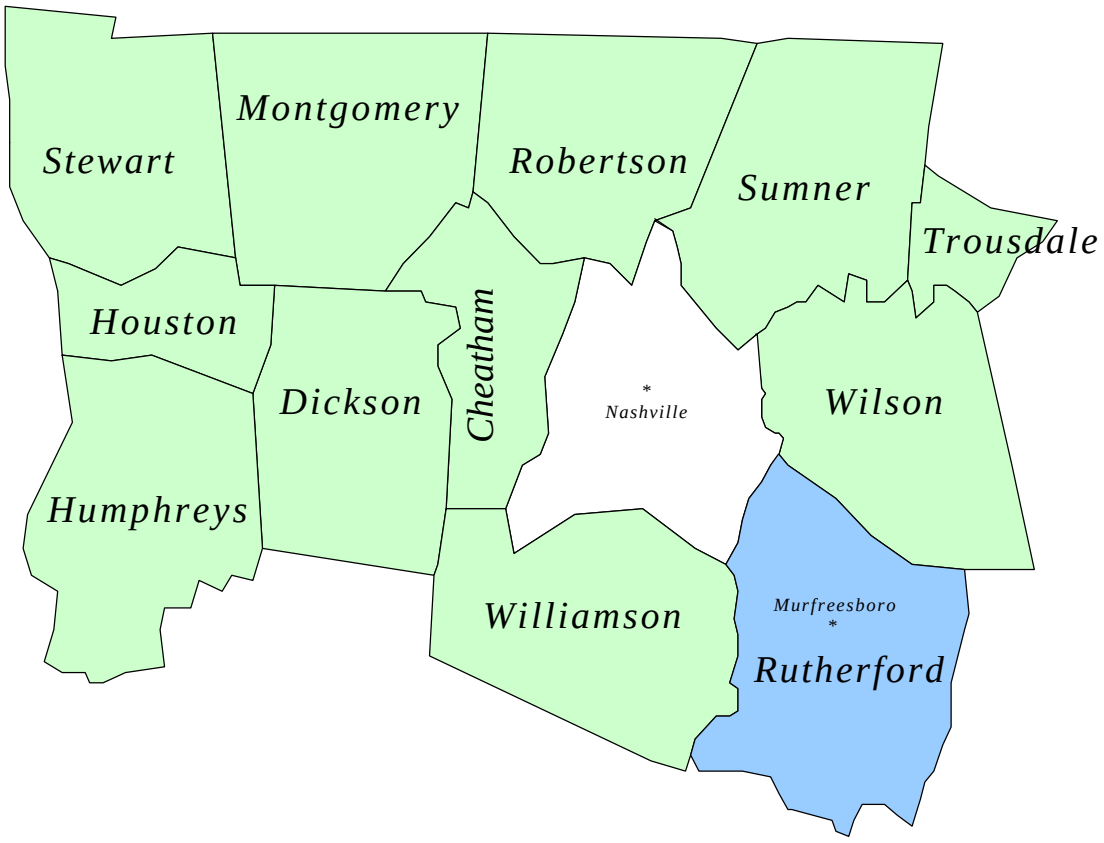
Community Diagnosis
Status Report
The Mid-Cumberland Region



The Community Wellness Council of Rutherford County

January 1998

INTRODUCTION:

The Community Diagnosis Process

A simple definition used by the North Carolina State Center for Health and Environmental Statistics of a community diagnosis is "a means of examining aggregate health and social statistics, liberally spiced with knowledge of the local situation, in order to determine the health needs of the community". Significant input from county residents is necessary to conduct a community diagnosis most effectively. The State has an abundance of data to be studied during this process, however the process can only be a success if there is community "buy-in". Thus, the need for the formation and participation of a county health council is an important part of the process.

A community-based "Community Diagnosis" process should prompt the county health council to ask the following:

Where is the community now? Where does it want to go? How will it get there?

It is evident that the community diagnosis process and its outcomes should, at a minimum,:

- Provide justification for budget improvement requests submitted to the State Legislature
- Provide to state-level programs and their regional office personnel information that fosters better planning, promotion, and coordination of prevention and intervention strategies at the local level;
- Serve health planning and advocacy needs at the community level. Here, the community leaders and local health departments provide the leadership to ensure that documented community health problems are addressed.

The end result of the process will be a set of prioritized health goals and proposed interventions to address the needs of the community.

The Tennessee Department of Health is committed to assisting communities throughout our state in finding the answers to these questions via the community diagnosis process.

This document will explain the community diagnosis process and outcomes for Rutherford County. We also hope to give a historical perspective and details of the Council and its formation.

CONTENTS

I. The Community Wellness Council of Rutherford County - Introduction

The Community Wellness Council of Rutherford County, which actually began as the Rutherford County Health Council, was developed after a meeting between Tennessee Department of Health Community Development Staff and local county officials. The County's Chamber of Commerce, County Executive, County Planning Department, and County Health Department all collaborated in June of 1996 to develop a list of potential council members. Prospective members were contacted and invited to a meeting to be held July 9. At this meeting, prospective members were introduced to the "Community Diagnosis" process and to the roles and responsibilities of the newly formed Rutherford County Health Council. A list of current members is included as "Attachment A". It is important to note that this list does not represent the initial membership, as a result of adding and deleting members throughout the existence of the Council.

During early meetings of the Council, the group developed a mission statement:

"To help the perpetual improvement of the health status of Rutherford County residents by promoting a health-conscious county, identifying priorities, establishing goals, and determining courses of action to improve the health status of the community. We will do this on an ongoing basis using the Community Diagnosis Process".

The Council has met monthly, up until January of 1998. The meeting schedule has now been changed to reflect a quarterly meeting schedule, with meetings held on the first Tuesday of the first month in each quarter (i.e. January, April, July, October). Meetings are open to the public from 8:00 – 9:00 a.m. Typically meetings are held at the Rutherford County Health Department.

Throughout the course of the Council's existence, it was unanimously decided that the Council change its name from the Rutherford County Health Council, to the Community Wellness Council of Rutherford Council to more closely reflect the purpose and activities of the Council. The Council has also established bylaws, and incorporated as a 501C3 nonprofit entity, so that they might apply for grant monies on behalf of the Council. The Bylaws and Charter of the Council are included as "Attachment B". According to the Bylaws of the Council, the Council must have a Chair, Co-Chair, and Treasurer. Both the Chair and Co-Chair were elected soon after the initial meeting, with a Treasurer elected after the decision to incorporate.

The Council has had the participation and support of Middle Tennessee Medical Center and Murfreesboro Medical Center, the Chamber of Commerce, the County Planning Office, the County Executive, and Middle Tennessee State University.

The Council has supplied information that has been published in “Health Watch”, a newsletter produced by MTSU’s Center for Health and Human Services, that has been distributed to various individuals and groups in the community that have a need and interest in health data and statistics. The Council has also appeared publicly on t.v., radio, and in several news articles publicizing its findings and promoting the work of the Council.

II. COUNTY DESCRIPTION

A Profile of Rutherford County

Rutherford County is an exciting and dynamic community. Using years 1980 through 1994, Rutherford County has proven to be the fastest growing county in the state. Projections for future growth show a continuing rate of increased growth that is one of the highest in the state. The county has four distinct community populations: Murfreesboro, which is the county seat, Smyrna, Lavergne, and Eagleville.

Rutherford County, which borders Metropolitan Nashville/Davidson County, is home to Middle Tennessee State University and Nissan Manufacturing. Also in the county are other major employers such as Bridgestone/Firestone, Ingram Distribution, Walden Books, Whirpool, Perrigo of Tennessee, Caradon Better-Bilt, National Healthcare (NHC), Square D Co. , the Alvin C. York Veteran's Administration Medical Center (mentioned below) and Middle Tennessee Medical Center. The Rutherford County Government is also a major employer.

Included with the county's many medical specialists and providers, are Middle Tennessee Medical Center, with 288 beds and over 100 physicians, and Alvin C. York Veteran's Administration Medical Center with 842 beds.

Approximately 50.8% of the family households, which number 47,603, are homeowners. The median home value is $71,800.

The county has a county school system, Murfreesboro City schools, and four private schools. Middle Tennessee State University is also located in Murfreesboro.

The county is culturally diverse, with attractions such as Stones River National Battlefield, Children's Discovery Center, and the Cultural Arts Center. The county also has a new YMCA, and Sportscom, a year-round indoor/outdoor facility with youth activities.

Information taken from the Nashville Area Chamber of Commerce, Rutherford County Chamber of Commerce, and the 1990 Census.

Total Number of Households: 42,118

	County	Region	State
Percent of households that are family households	74.1	78.8	72.7
Percent of households that are families headed by a female with no husband present	10.1	9.7	12.6
Percent of households that are families headed by a female with no husband present and with children under 18 years	6.3	5.7	6.9
Percent of households with the householder 65 and up	14.6	17.1	21.8

EDUCATION

	County	Region	State
Number of persons age 25 and older	70,105	380,119	3,139,066
Percent of persons 25 and up that are high school graduates or higher	73.9	71.9	67.1
Percent of persons 25 and up with a bachelor's degree or higher	18.7	17.1	16.0

EMPLOYMENT

	County	Region	State
Number of Persons 16 and Older	90,231	464,333	3,799,725
Percent In Work Force	71.1	69.1	64.0
Number of Persons 16 and Older in Civilian Work Force	64,004	307,228	2,405,077
Percent Unemployed	4.7	5.3	6.4
Number of Females 16 Years and Older with Own Children Under 6	7,487	40,261	287,675
Percent in Labor Force	65.8	63.2	62.9

POVERTY STATUS	County	Region	State
Per capita income in 1989	$12,536	$13,213	$12,255
Percent of persons below the 1989 poverty level	10.8	10.52091	15.7
Families with children under 18 years, percent with income in 1989 below poverty level	11.0	12.0	20.7
Percent of persons age 65 years and older with income in 1989 below the poverty level	20.4	19.3	20.9

Sources: U.S. Department of Commerce, Bureau of the Census, 1990 Census of Population General Population Characteristics, Tennessee, and 1990 Census of Population and Housing, Summary Social, Economic, and Housing Characteristics Tennessee.

III. COMMUNITY NEEDS ASSESSMENT

The following is a list of both primary and secondary data reviewed by the Council members. This information was discussed initially as a group, and then discussed in more detail through subcommittees that were formed. A list of subcommittees is as follows:

- Children, Youth, and Families
- OB/GYN and Prenatal Issue
- Preventive Care
- Elderly

Data Reviewed:

Primary Data:

- "Stakeholder's Survey" – Approximately 32 out of 60 surveys were returned from "stakeholders" in the community. The surveys asked questions about important health issues facing the county, as well as about resources available or needed in the county. Stakeholders were defined as any resident of the county who had a "first-hand knowledge and/or interest in the health and healthcare of the county". Members of the Council were asked to complete a survey and to recruit other community participants to complete the survey. This survey was not a scientific survey, but was intended to obtain subjective data from a sampling of the community.

- "Perceptions of the Council Members" – Council members (numbering 30) were surveyed on their perceptions of important health issues, strengths and weaknesses of their community.

- 1996 "Behavior Risk Factor Survey" – A telephone survey on health behaviors as well as community health concerns, conducted by the University of Tennessee (Knoxville) was done by telephone, to approximately 200 county residents. The survey was modeled after the BRFS survey conducted by the Centers for Disease Control.

- 1996 "Tennessee Alcohol, Tobacco and Other Drugs High School Survey"- In this Tennessee Department of Health Survey, a total of 137 high schools with students in grades 9-12 were surveyed across the state. RutherfordCounty High Schools were not participants in the survey, however. Results from the region were used to form general conclusions about the county. Questions on the survey asked about participation in various alcohol and drug prevention programs as well as personal alcohol, tobacco, and other drug use.

- 1993 "Tennessee Alcohol, Tobacco and Other Drugs Survey" (Adult Household) – Approximately 8000 Tennessee residents were surveyed by telephone by the University of Tennessee (Knoxville), in conjunction with the Tennessee Department of Health, Bureau of Alcohol and Drug Services. Approximately 140 county residents participated in this survey. The survey topics included health and disability status, medical care utilization, stress and coping, health care access problems, the prevalence of alcohol and other drug use, abuse and associated problems, the social context of alcohol consumption, risk factors in AOD use, attitudes and opinions concerning a host of alcohol-and-other-drug-related issues and problems, such as alcoholic beverage sales and service to minors and to intoxicated persons, drunken driving, HIV/AIDS, community knowledge of certain drug effects and relationships; and sample sociodemographic characteristics.

Secondary Data:

- 1990 Census Demographics
- "Rutherford County Health Statistics – 1984 – 1995" – Summary of Dept. of Health Data (mortality and morbidity data, pregnancy and birth data, health care resources, public health program data)
- "Tennessee's Health, Picture of the Present" 1994
- 1996 Tennessee's "Healthy People 2000"
- AIDS data – Tennessee Dept. of Health
- 1995 "Assessment of TennCare Dental Coverage" 1995
- Other Program and Health Department Data
- "1994 Status Report on Adolescent Pregnancy"

IV. Health Issues and Priorities

Upon completion of the data review, all Council members were asked to complete a prioritization process which used size and seriousness as factors in determining which health issues had highest priorities. The "Scoring Sheet" is included as "Attachment C".

Health Priorities

	Subcommittee/Population:	Issue:	Score:
1.	Children, Youth, Families	Teen Pregnancy/Drugs	48
2.	Preventive Care	Cardiovascular Disease	55
3.	Preventive Care	Cancer	79
4. (tie)	Preventive Care	STDs	95
4. (tie)	OB/GYN and Prenatal	Access/Inadequate resources for indigent/uninsured	95
6.	Elderly	High Cost of Health Care	96
7.	Children, Youth, Families	Inadequate resources for for school health care	97
8.	Elderly	Lack of education/prevention	101
9.	Elderly	Access to Care	104
10.	OB/GYN and Prenatal	Late entry into prenatal care	109
11.	OB/GYN and Prenatal	High rate of smoking with pregnant women/women of childbearing age	113
12.	Children, Youth, Families	Lack of coordination/duplication of services	123

IV. Future Planning

After results of the ranking of health issues were discussed at the January 1997 meeting, the Council decided to initially focus its efforts on the #2 health priority, cardiovascular disease. The group felt this was an issue that was relevant to the entire population, and would be a good starting point to begin as a group.

Priority #2: Cardiovascular Disease:

Problem: Cardiovascular Disease

Rutherford County has a high rate of cardiovascular disease, as evidenced by the data. Not only is the County higher than the National "Healthy People 2000" goals, the "Behavior Risk Factor Survey" results showed high rates of smoking (29.5% of respondents smoked cigarettes everyday), poor nutrition (50% reported they didn't follow

recommended dietary guidelines for optimal nutrition), and lack of physical activity (24% got no physical activity in the past month). All of these risk factors can lead to high rates of cardiovascular disease.

Goals/Objectives/Activities:

The Council wanted to pursue an activity that would provide general awareness of cardiovascular disease and educate the public about the role of the Council, with the overall goal to reduce cardiovascular disease. It was decided that a community-wide health "carnival", with a focus on the family", would be planned for August 23, 1997 at MTSU's Murphy Center. It was the intent of the group that this would be a one-time "kick off" event, which would later be targeted to areas of the community "at-risk". The event was a success, with over 500 residents in attendance. Activities that took place included health screenings for risk factors, classes on "heart healthy" topics, demonstrations by local dance teams and schools, and several fitness walks. In future years, the Council intends to coordinate efforts with other groups coordinating similar events, and to supply information and relevant data as needed to the community through these type of events.

The "Preventive Care" subcommittee continues to meet to develop additional recommendations for this health priority, as well as **for Priority # 3 Cancer, and Priority #4 , STDS.**

Problem: Cancer

Rutherford County ranked #17 out of 95 for breast cancer rates, with 24.8 deaths per 100,000. Rates for the county were higher than the state rates and the national objectives. Deaths from lung cancer were also higher than the national objectives. Cancer was one of the top three leading causes of death for almost every age group. It was the number one cause for ages 25-44 and 45-64. Trend information that was available was unstable. The 1996 "Behavior Risk Factor Survey" showed that 29.5% of respondents currently smoke cigarettes, 55% seldom or never eat fruits and vegetables on a daily basis, 65% seldom, or never eat 6 or more servings of grains on a daily basis, and 43% report obesity as being a problem in the community. Each of these may contribute to risk of cancer.

Problem: STDS

Syphilis rates have increased 159% in both white and nonwhite females aged 25-44 over the 1983-1994 time period. The County is above the national objective of 10 per 100,000 at 13.6 per 100,000; the County is below the state rate of 70.8. Chlamydia rates have also increased overall by 212.% over the same twelve year time period. In ages 25-44 they have increased 422.9%. Gonorrhea rates have actually shown overall decreases.

Priorities #1 Teen Pregnancy/Drugs, #7 Inadequate Resources for School Health Care, and #12 Lack of Coordination/Duplication of Services for children, youth, and families:

Problem: Teen Pregnancy/Drugs

Rutherford County had a lower rate than the State for teenage pregnancy (24.2% for the State vs. 17.8% for Rutherford County). No national objective has been determined. Overall numbers of teen pregnancies have shown increases over the 1983-1994 time period. The 1996 "Behavior Risk Factor Survey" showed that teen pregnancy was one of the "top five" community problems. The "Stakeholders Survey" also indicated that teen pregnancy and drugs were problems. According to the 1996 "Tennessee Alcohol and Drug High-School Survey" approximately 20.2% of students in the Mid-Cumberland Region bought an illegal drug in the last 12 months. Approximately 40.8% have ever used marijuana.

The Children, Youth, and Families subcommittee will meet with the "American Community Summit of Rutherford County" subcommittee on Health to discuss recommendations and activities for these particular issues. November 6-8 a county-wide "Community Summit", modeled after the National Summit for children, was held in Rutherford County. Several Council members were participants of this event which included approximately 264 participants, of which 58 were youth. The goals of the "Summit" were to promote opportunities and overall health and wellbeing for the youth of the County.

Problem: Inadequate Resources for School Health Care

According to the "Rutherford County School Health Survey" done by the School System, the following conclusions were reached: Teachers desire to be relieved of health care responsibilities. Out of all respondents, 32% spent a half-hour to 1 hour per school day dealing with health, behavioral, mental, or emotional problems, while 12.7% spent 1+ hours per school day on these issues. The overwhelming majority of all respondents have a low comfort level for performing health care. The majority of medication is dispensed in school offices by personnel who have the least health care training. Secretaries indicated more than other respondents, that they have had no training in CPR, First Aid, Health, and Inservice.

Problem: Lack of Coordination/Duplication of services

Lack of coordination and duplication of services was listed as an important community issue in the 1996 "Stakeholders Survey" and was also identified by the American Community Summit of Rutherford County participants.

This problem has been directly addressed through the Council's participation in the 1997-1998 "Governor's Community Prevention Initiative for Children", (GCPIC) and through the input of the "Summit". After much discussion, it was evident that many resources

addressing the needs of children, youth, and families in the community, but many were unaware of those services or how to access them. A "Community Resource and Referral Center" with limited case-management was proposed under the GCPIC initiative, which would provide not only a central hub for information on needed services for children, youth, and families, but would also provide a central network to link youth and adults with volunteer opportunities that may be available in the community. Approval for this proposal is still pending.

Priorities #4, Access/inadequate resources for indigent/uninsured (OB/GYN & Prenatal), # 10, Late Entry into prenatal care, and #11 High rates of smoking in pregnant women/women of childbearing age:

Problem: Access/inadequate resources for indigent/uninsured

Affordability and high cost of medical care were listed as important issues in the "Stakeholder's Survey" and the "Council Members Survey". In the 1996 "Behavior Risk Factor Survey", 25% of respondents indicated lack of financial resources for medical care was a problem in the County. Approximately 14% of respondents needed to see a doctor but could not due to cost.

Problem: Late Entry into prenatal care

The County is above the national objective of 10 per 100,000 with 18.6 per 100,000 women getting late prenatal care (late care includes 2nd and 3rd trimester care plus no prenatal care). The County is below the State, however, with 18.6 per 100,000 vs. 19.9 per 100,000 for the State.

The OB/GYN Pregnancy and Prenatal Subcommittee continues to meet to develop recommendations for priorities #4 and 10. It has developed the following recommendations to address the issue of the high rates of smoking in pregnant women/women of childbearing age:

Problem: High rates of smoking/low birthweight babies

In Rutherford County there has been an increase in risk factors associated with low birthweight babies (i.e. smoking, hypertension, and diabetes) according to six year averages from 1989-1994. The County is above the national objective for low birthweight of 5.0, with a rate of 7.2 per 100.

Goal: To reduce smoking by 10% at one year in a group of smokers of child bearing age who have received the recommended program.

Objective: A. To encourage the State to adopt a state-wide program to promote personal responsibility through contracts with pregnant women to stop smoking while pregnant. (Incentives should be included). B. Promote school-based program to prevent initiation of smoking by children.

Activities:

Project A:
1. Work with a private or public agency to implement contracts in prenatal clinics. Require contracts of all prenatal TennCare providers and patients at initiation of prenatal care.
2. Require contracts of all prenatal TennCare providers and patients at initiation of prenatal care

Project B:
Work with the local boards of education and the State Dept. of Health to formulate an ongoing anti-smoking education program consistent with the recommendations of the 1996 Surgeon General's report on preventing smoking in youth.

Priorities #6, High Cost of Health Care, # 8 Lack of education/prevention services, and #9 Access to Care (all for the elderly population):

Problem: High Cost of Health Care

Affordability and high cost of medical care were listed as important issues in the "Stakeholder's Survey" and the "Council Members Survey". In the 1996 "Behavior Risk Factor Survey", 25% of respondents indicated lack of financial resources for medical care was a problem in the County. Approximately 14% of respondents needed to see a doctor but could not due to cost. According to statistics provided by National Healthcare, approximately 24% of householders aged 65-69 had incomes under $10,000 in 1996, and 25% of those aged 70-74 had incomes under $10,000. The median projected income for ages 65-69 in 2001 is $28,499.

Problem: Lack of education/prevention services

Lack of education and prevention services was cited in the 1996 "Stakeholder's Survey", the "Council Members Survey", and the 1996 "Behavior Risk Factor Survey". The lack of resources can also be evidenced by the high rates of preventable diseases outlined in other areas of this report.

Problem: Access to Care

Again, as mentioned above, affordability is one access issue for the elderly. Other issues include transportation (cited as a problem by only 6% of "1996 "Behavior Risk Factor Survey" participants), access to dental care (cited as a problem by 18% of respondents), access to eye care (cited as a problem by 12% of respondents), access to daycare for homebound (cited as a problem by 10% of respondents), home health (cited as a problem by 4%). It is important to note that only 29 of the 200 surveyed were age 65+, so the results may not reflect this population's issues.

Representatives from agencies serving the elderly population have been invited to Council meetings to discuss services and interventions currently in the community. The "Elderly" subcommittee continues to meet to discuss appropriate recommendations and interventions.

In Conclusion:

The "Community Diagnosis" process does not stop with this document. The process is intended to be on-going, continually assessing the health status and interventions of the county. Other new priorities and interventions as well as progress with current priorities and interventions will follow in future documents.

Attachment A

Community Wellness Council of Rutherford County
(Updated 1/99)

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Community "Summit" of
Rutherford County

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Attachment B

Bylaws

Bylaws of the Council are presently unavailable online.

Attachment C

Rutherford County Health Council - Health Priorities

Please rank the following most frequently identified health issues according to the **size** of the problem (what portion of the population does it affect?) and the **seriousness** of the problem. (With #1 being most serious and #12 being the least serious).

		Size: (1-12)	+	Seriousness: (1-12) X 2	Total:
	Children/Youth:				
_____	Teen Pregnancy/Drugs	_____	+	(___) X 2 =	_____
_____	Inadequate Resources for school health care	_____	+	(___) X 2 =	_____
_____	Lack of coordination/duplication of services	_____	+	(___) X 2 =	_____
	Preventive Care:				
_____	Cancer	_____	+	(___) X 2 =	____ _____
_____	Heart Disease	_____	+	(___) X 2 =	____ _____
_____	STDS	_____	+	(___) X 2 =	____ _____
	Elderly:				
_____	Access to Care	_____	+	(___) X 2 =	____ _____
_____	High Cost of Health Care	_____	+	(___) X 2 =	____ _____
_____	Heart disease	_____	+	(___) X 2 =	____ _____
	OB/GYN/Prenatal:				
_____	Access/Inadequate Resources for indigent/uninsured	_____	+	(___) X 2 =	____ _____
_____	Late Entry into prenatal care	_____	+	(___) X 2 =	____ _____
_____	High rate of smoking in pregnant women/women of childbearing age	_____	+	(___) X 2 =	____ _____

Attachment D

HIT: Health Information Tennessee

Monitoring the Health of Tennessee
(use "server.to/hit" or "http://web.utk.edu/~chrg/hit" to visit this site)

HIT is a pilot project to disseminate data

•to identify population health problems and high risk groups, and
•to assess need for prevention, treatment, and rehabilitation services in Tennessee.

This is an official web site of the Tennessee Department of Health and The University of Tennessee, Community Health Research Group.

Be sure to visit SPOT and MAPS/GIS to fully utilize the innovative features of this interactive data site.

Browser Suggestions

The SPOT data analysis section of HIT is best viewed with Netscape(Free!).

At present Internet Explorer is not correctly processing the javascript which underlies the interactive map feature of SPOT. If you do use Internet Explorer then this will be detected by HIT whenever you navigate to or from a javascript enabled area such as SPOT. A warning box will appear asking that you read this explanatory file. Click on the OK button and proceed. You will still be able to view the maps, but the ability to click on an area of the map in order to make an area selection will not function. The selection boxes below each map are also dependent on javascript. All job submission and retrieval will work with Internet Explorer 3.0 or later. However, unless you are using Internet Explorer 4 or later, the automatic county identifier feature of SPOT, which is found in both the shaded map and county comparison plot outputs, will be disabled.

We are currently working on the Internet Explorer VBScript code that will parallel Netscape's JavaScript. Since Netscape is now free (as is Internet Explorer) and you can have both Internet Explorer and Netscape installed on your computer simultaneously we hope that you will be patient.

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Please contact us if you have any questions or to report a problem or error. e-mail CHRG